(11)

No. 88-2043

In the Supreme Court
OF THE
United States

OCTOBER TERM, 1989

GERALD L. BALILES, et al.,
Petitioners,
v.
THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF *AMICI CURIAE* CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS, AND UNITED HOSPITAL ASSOCIATION IN SUPPORT OF RESPONDENT'S POSITION

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INTERESTS OF *AMICI CURIAE*

The California Association of Hospitals and Health Systems, California Association of Public Hospitals, and United Hospital Association respectfully submit this brief in support of the position of respondent Virginia Hospital Association. The California Association of Hospitals and Health Systems ("CAHHS") is a statewide organization of non-profit, investor-owned, public, rural and district hospitals which seeks to promote the health and well-being of the residents of California. The California Association of Public Hospitals ("CAPH") is a California non-profit corporation, the members of which are public hospitals owned and operated by counties throughout California. The United Hospital Association is a California non-profit corporation which represents the interests of investor-owned hospitals in the State of California. Its purposes are to preserve the hospital as an American free enterprise institution and to coordinate efforts to furnish quality patient care at the lowest possible cost.[1]

Amici have a vital interest in the proceedings in this matter because their members provide a substantial portion of inpatient and outpatient hospital services delivered under California's Medicaid program, known as "Medi-Cal," administered by the State Department of Human Services ("SDHS"). *Amici* are concerned that Congress's directive that Medicaid payment rates be "reasonable and adequate . . . to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. . . ," 42 U.S.C.A.

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[1]CAHHS, CAPH and UHA have requested and obtained the written consent of the parties to file this *amici curiae* brief in support of respondent's position. The letters containing the written consents are on file with the Clerk of this Court.

§ 1396a(a)(13)(A) (West Supp. 1989), has not been achieved. Although California hospitals incur an average operating expense of $294 per day for medical/surgical acute care, the Medi-Cal program reimburses them in the average amount of $156 per day, or 53 percent of their operating expenses. (California) Office of Statewide Health Planning and Development, *Individual Hospital Financial Data for California* at xii (1989). SDHS's Medi-Cal payments are 30 percent lower than the average daily payment made under the Medicare program, and 58 percent lower than payments made by other payor sources. *Id.* As a result of such payments, in fiscal year 1988 California hospitals lost a combined total of $947 million for services rendered under the Medi-Cal program. (California) Office of Statewide Health Planning and Development, *Quarterly Aggregate Hospital Data for California,* 2-2, 4-2, 6-2, 8-2 (1988).

The section 1983 remedy recognized by the Fourth Circuit in the proceedings below (*Virginia Hosp. Ass'n v. Baliles,* 868 F.2d 653 (4th Cir. 1989)) and other courts of appeals is a critical mechanism by which health care providers can obtain review of payment levels established by the states. In California, as elsewhere, the administrative appeal procedure established by the state's administering agency will not examine the sufficiency of the underlying payment methods established by the agency and, in particular, whether those methods comply with federal program directives. *See* 22 Cal. Code Regs. §§ 51536(h)(1) and (i)(2), 51539(d)(2). Actions such as that brought by the Virginia Hospital Association, far from frustrating the purposes of the Medicaid program, are an efficient and logical means of assuring that Medicaid recipients obtain proper and effective medical treatment.

SUMMARY OF ARGUMENT

Earlier this year the United States Court of Appeals for the Fourth Circuit held that Virginia hospitals may, pursuant to 42 U.S.C. § 1983, challenge Virginia's methods for reimbursing them for the cost of treating Medicaid patients. *See Virginia Hosp. Ass'n v. Baliles,* 868 F.2d 653 (4th Cir. 1989). The court of appeals determined that the language and legislative history of title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. §§ 1396 *et seq.* (known as the "Medicaid Act"), compelled the conclusion that health care providers which treat Medicaid recipients may enforce a right to a minimum level of payment under the statute. In so holding, the Fourth Circuit aligned itself with every court of appeals which has considered the issue. After the Fourth Circuit issued its decision, the Third Circuit, in *West Virginia Univ. Hosps., Inc. v. Casey,* 885 F.2d 11 (3d Cir. 1989), independently examined the statutory text and legislative history, and came to the identical conclusion that health care providers are entitled to enforce the statutory directive that payment rates for Medicaid services be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality . . ." 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989).

The unanimous conclusion of these appellate courts that a health care provider may avail itself of a section 1983 remedy to ensure state compliance with the mandates of the Medicaid Act is convincingly supported by the text of the Act and its legislative history. Adhering to this Court's precedents under section 1983, the courts have first examined whether the Medicaid Act confers

certain enforceable rights on an approved health care provider which furnishes medical care under the program. The courts have correctly concluded that the Act's directives (which are coupled with substantial federal financial assistance) that each participating state establish minimum levels of reimbursement are mandatory. The courts have also examined the legislative history of the 1981 amendments to the Act, and have found a clear and unambiguous design by Congress to maintain a federal minimum standard of reimbursement, while at the same time permitting the states greater flexibility in meeting that standard. The courts have also found that an authorized provider is an intended beneficiary of the Act's payment standards, inasmuch as Congress's ultimate objective of providing care for the medically indigent depends entirely on compliance with a minimum level of provider reimbursement. (Moreover, in 1981 Congress had full knowledge that providers had sought and obtained judicial review of state payment methods, and left such avenues open to them.)

The Fourth Circuit, like the other courts of appeals which have considered this issue, also considered whether Congress specifically foreclosed a remedy under section 1983 by express provision, or by providing a comprehensive mechanism for the enforcement of provider rights under the Act. The courts are again unanimous in concluding that the compelling showing required under *Wright v. City of Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418 (1987), of a legislative intent to foreclose the use of the section 1983 remedy cannot be made in this instance. The Medicaid Act itself does not contain a provision that expressly forecloses the use of section 1983, a fact which all concede. The limited review procedures available under the program do not come close to the "comprehensive enforcement mechanism[ ]" from which Congress's intent to foreclose could be inferred

(*Smith v. Robinson*, 468 U.S. 992, 1003 (1984)), but are strikingly similar to the generalized federal review powers that were examined by this Court in *Wright*, and found to be insufficient to foreclose the use of section 1983.

ARGUMENT

I.

HEALTH CARE PROVIDERS HAVE A RIGHT TO REASONABLE PAYMENT FOR SERVICES RENDERED UNDER THE MEDICAID ACT THAT MAY BE ENFORCED UNDER 42 U.S.C. § 1983

This Court granted certiorari to decide whether a Medicaid provider may avail itself of the broad remedial provisions of 42 U.S.C. § 1983 to enforce a state's failure to comply with minimum standards of payment under the Medicaid Act. Section 1983 provides a remedy for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C.A. § 1983 (West Supp. 1989). Earlier this month this Court emphasized its "repeate[d] [holdings] that the coverage of the statute must be broadly construed." *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 2 (Dec. 5, 1989). The statute "provides a remedy 'against all forms of official violation of federally protected rights.'" *Id.* (quoting *Monell v. New York City Dep't of Social Services*, 436 U.S. 658, 700-701 (1978)). The class of "federally protected" rights under section 1983 includes rights secured by federal statutes (*Maine v. Thiboutot*, 448 U.S. 1, 4 (1980)), and by federal regulations (*Wright*, 479 U.S. at 424-425).

This Court employs a two-step analysis to determine whether a statutory or constitutional violation may be remedied by section 1983. First, the federal law must create private rights enforceable under section 1983. *Pennhurst State School and Hosp. v. Halderman*, 451 U.S.

1, 19 (1981). Second, assuming that a federal right is involved, the defendant may establish that Congress "specifically foreclosed a remedy under 1983," *Smith*, 468 U.S. at 1005 n. 9, by providing a "comprehensive enforcement mechanis[m] for protection of a federal right." *Id.* at 1003.

The first question raised by this appeal, then, is whether the payment sections of the Medicaid Act and its implementing regulations create rights in favor of those health care providers which provide medical care under the Act. The issue is *not* — as petitioners repeatedly suggest — whether Congress intended to create an "implied right of action" under the Act. *See* Brief of Petitioners at 11, 17, 21.[2] Petitioners' brief confuses the related but distinct analyses of rights of action under section 1983 and implied rights of action under a substantive

[2]Petitioners argue throughout that neither the Medicaid Act nor the 1981 Boren Amendment evinces a congressional intent to create an "implied right of action," relying on this Court's implied right of action decisions (most notably, *Cort v. Ash*, 422 U.S. 66 (1975)). For example, petitioners state that "the implied right of action cases under § 1983 increasingly look to legislative intent to create a cause of action as the dispositive factor in determining whether § 1983 is available to enforce a violation of a federal statute against a state." Brief for Petitioners at 11. The ascertainment of a legislative intent "to create a cause of action" is not even relevant to an analysis under section 1983, let alone a "dispositive factor." As this Court has pointed out on numerous occasions (*see Thiboutot*, 448 U.S. at 4), section 1983 itself is a remedy expressly intended by Congress.

Petitioners' further suggestion that the absence of "an express right enforceable by a Medicaid provider against a State," Brief of Petitioner at 12 n. 3, may be taken as an indication of congressional intent *not* to recognize provider rights has no support in the decisions of this Court. This suggestion conflicts directly with *Thiboutot*, where the Court held that a section 1983 right of action was available to enforce the Social Security Act *notwithstanding* the absence of a right of action under that Act. *See* 448 U.S. at 5–6.

statute, and in so doing holds providers to a false standard. These are different inquiries which intersect only on the issue of whether the underlying statute confers an enforceable right on the plaintiff. *See Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 19 & 20 n. 31 (1981). In contrast to the showing required to establish an implied right of action, "the plaintiff who seeks to enforce a federal statutory right under section 1983 need not demonstrate congressional intent to provide access to that remedy," *Boatowners and Tenants Ass'n, Inc. v. Port of Seattle*, 716 F.2d 669, 674 (9th Cir. 1983), since "§ 1983 itself provides for private enforcement." *West Virginia Univ. Hosps.*, 885 F.2d at 18-19 n. 1. Thus, the issue here is simply whether a participating provider has a right under the Medicaid Act to a minimum level of payment.

A. The Medicaid Act Establishes a Minimum Standard of Reimbursement of Authorized Health Care Providers

A health care provider which provides medical care for Medicaid recipients has a right to be paid in accordance with minimum standards of reimbursement. This conclusion is supported by the text of the Medicaid statute, the pertinent legislative history, and the implementing regulations of the Health Care Finance Administration ("HCFA"), the agency within the Department of Health and Human Services responsible for overseeing the Medicaid program.

As petitioners have pointed out, the Medicaid statute is extraordinarily complex. One of the main reasons for this complexity is the number of parties which have a role in the system, and the concomitant necessity of coordinating various responsibilities among them. The states, of course, do not directly furnish care for Medicaid recipients, but instead rely upon qualified health care providers. Earlier this year the Third Circuit aptly

characterized the Medicaid Act as a "cooperative mosaic through which the federal government reimburses a portion of the payments made by participating states to hospitals and other providers furnishing care to eligible needy persons." *West Virginia Univ. Hosps.*, 885 F.2d at 19.

A state that chooses to participate in the program is obligated to develop a state Medicaid plan that complies with federal statutory and regulatory conditions of funding. These conditions are numerous, and are contained in no less than fifty subsections of section 1902(a). It is difficult to conceive of a more comprehensive set of program standards. A state's plan must contain methods of administration "as are found by the Secretary to be necessary for the proper and efficient operation of the plan" (§ 1396a(a)(4)(A)); designate a single state agency to administer the plan (§ 1396a(a)(5)); ensure that medical assistance is available to individuals who qualify under any one of several qualifying provisions (§ 1396a(a)(10)(A)); and provide for reports to the Secretary "as the Secretary may from time to time require." (§ 1396a(a)(6).)

A number of state plan requirements expressly concern reimbursement for services furnished under the Act. In this case the Virginia Hospital Association has alleged that Virginia has failed to comply with section 1902(a)(13)(A), 42 U.S.C. § 1936a(a)(13)(A), one of a number of sections that concern payments to providers. This subsection provides, in pertinent part:

> A State plan for medical assistance *must* —
>
> . . .
>
> (13) provide —
>
> (A) for payment . . . of the hospital . . . services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities . . .

42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989) (emphasis supplied). Subsection (30)(A) stipulates that the state plan "provide such methods and procedures relating to . . . the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care. . ." 42 U.S.C.A. § 1396a(a)(30)(A) (West Supp. 1989).[3] Provider reimbursement is also addressed in subsection 37(B), which requires the Medicaid agency to provide "procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program . . . ." 42 U.S.C.A. § 1396a(a)(37)(B) (West Supp. 1989).

The payment sections of the statute, like all of the Act's requirements for state administration, are cast in the imperative. Each provision is prefaced with the directive that "[a] State plan for medical assistance must . . . ." "The language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge' . . . in the direction of providing

[3]Although the Virginia Hospital Association's pleading in the District Court does not contain a subsection (30)(A) claim, such a claim would appear available to it on the basis of the facts alleged.

appropriate reimbursement of hospitals treating Medicaid patients." *West Virginia Univ. Hosps.*, 885 F.2d at 20.

Even if the plain language of the statute were not so clear, the legislative history confirms Congress's purpose to maintain minimum reimbursement standards. Prior to the enactment of the 1981 Boren Amendment, the law required each participating state to reimburse providers on a "reasonable cost" basis for inpatient services under Medicaid. This method of reimbursement was thought to result in unnecessarily high program costs. *See* H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 279, 292 (1981). Congress believed that states should be given the flexibility to develop "alternative reimbursement methodologies that promote the efficient and economic delivery of such services." *Id.* By granting states more latitude in setting payment rates, however, Congress did not thereby intend to *eliminate* federal payment standards. Rather, Congress substituted *new* reimbursement standards.[4] This is clear from the House Budget Committee's comments on H.R. 3982, the bill that ultimately became Public Law 97-35:

> This section eliminates the current requirement that States pay hospitals on a Medicare 'reasonable cost' basis for inpatient services under Medicaid. The Committee bill *requires instead* that Medicaid payments be 'reasonable

[4]Petitioners misinterpret a congressional design for greater state flexibility as a complete abdication of federal standards. *See* Brief for Petitioners at 20 (The 1981 Boren Amendment reflects a "legislative choice to allow state-specific latitude in determining appropriate methodologies for payments to providers.") While Congress's purpose to grant greater flexibility to the states cannot be doubted, it does not follow that Congress thereby proposed to relieve states of their obligation to establish minimum standards of reimbursement necessary to achieve the program's objectives. In fact, the legislative history plainly indicates Congress's contrary intent.

> and necessary to the efficient and economical delivery of services.'

Id. at 292 (emphasis supplied).

The Senate also intended the new standards to be binding on the states. The Report of the Conference Committee noted that the Senate bill would fix new federal reimbursement standards:

> The Senate amendment also repeals the current law provision. It *requires* that State payments for inpatient hospital services be 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities' in order to meet applicable laws and quality and safety standards.

H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 962 (*reprinted in* 1981 U.S. Code Cong. & Ad. News 396, 1324) (emphasis supplied).[5]

[5]Despite these clear expressions of Congress's intent, petitioners argue that it may be inferred from the "contemporary legal context" at the time of the 1981 Boren Amendment that Congress did not intend to confer rights on providers. *See* Brief of Petitioners at 21-22. There are several problems with this argument. First, it improperly incorporates analysis from this Court's "implied right of action" decisions, an error that has been previously pointed out. *See* pp. 6-7, *supra*, & n. 2. Second, to the extent this argument has any relevance in the section 1983 context, it cuts in favor of providers. At the time of Congress's deliberation on amendments to the Medicaid Act, a number of providers had brought actions challenging various aspects of state program administration. *See Minnesota Ass'n of Healthcare Facilities, Inc. v. Minnesota Dep't of Public Welfare*, 602 F.2d 150, 152 (8th Cir. 1979) (nursing home providers had standing to assert claim that state Medicaid regulations violated the Social Security Act); *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357, 1361 (9th Cir. 1979) (ceiling on reimbursable costs did not violate Medicaid Act but federal approval of the plan did not satisfy the Act's requirements); *Massachusetts General Hosp. v. Weiner*, 569 F.2d 1156, 1161 (1st Cir. 1978) (provider challenge to Medicaid reimbursement rates failed on

The mandatory character of the Act's payment standards is confirmed in the governing regulations. HCFA interprets section 1902(a)(30) to "*require*[ ] that payments for services be consistent with efficiency, economy, and quality of care." 42 C.F.R. § 447.200 (1988) (emphasis supplied). To satisfy this requirement, "[t]he agency's payments *must* be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204 (1988) (emphasis supplied). The regulations also call for each state Medicaid agency to make annual findings that its payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations

the merits); *Alabama Nursing Home Ass'n v. Califano*, 465 F. Supp. 1183, 1187, 1189 (D. Ala. 1979) (considering merits of claim of inadequate Medicaid reimbursement by nursing home facilities), *rev'd in part, vacated in part, Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980); *Briarcliff Haven, Inc. v. Department of Human Resources*, 403 F. Supp. 1355, 1364 (D. Ga. 1975) (challenge to reimbursement provisions of the Medicaid Act failed on the merits); *Massachusetts General Hosp. v. Sargent*, 397 F. Supp. 1056, 1062 (D. Mass. 1975) (delay of reimbursement for inpatient care violated Medicaid Act); *Opelika Nursing Home, Inc. v. Richardson*, 356 F. Supp. 1338, 1345 (D. Ala. 1973) (challenge to regulation limiting payment under the Medicaid program denied on the merits). Implicit in each of these cases was that Medicaid providers had enforceable rights under the Medicaid program that could be enforced in federal court. *Cf. Thiboutot*, 448 U.S. at 5-6 (prior Social Security Act decisions necessarily relied on § 1983 as the exclusive statutory cause of action). Congress, of course, was aware of these decisions, and did nothing in either the 1980 or 1981 amendments prospectively to curtail such claims. Although in 1981 Congress revised the payment *standards* for inpatient services, it did not modify the basic statutory framework, which it well understood had enabled providers to obtain federal court review of payment levels.

and quality and safety standards...." 42 C.F.R. § 447.253(b)(1)(i) (1988). HCFA also requires each state to verify that payment rates for inpatient hospital services are "adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality." § 447.253(b)(1)(ii)(C) (1988).

The mandatory directives set forth in § 1396a contrast sharply with the text examined by this Court in *Pennhurst*. There, the Court was justifiably concerned that "indeterminate" statutory phrases such as "appropriate treatment" in the "least restrictive environment" to confer enforceable rights upon mentally retarded individuals would lead to consequences unforeseen by Congress and the states. The Court noted that "Congress fell well short of providing clear notice to the states that they, by accepting funds under the [Developmentally Disabled and Bill of Rights] Act, would indeed be obligated to comply with" the section of the Act under which the plaintiffs claimed a right. 451 U.S. at 25. The Court was particularly disturbed by the fact that Congress had provided the states $1.6 million, "a sum woefully inadequate to meet the enormous financial burden," *id.* at 24, that would be imposed on the states if the Act were construed to establish enforceable rights. The Court concluded that the "Bill of Rights" portion of the Act did not create rights that could be enforced under section 1983, but indicated a mere "congressional preference for certain kinds of treatment." 451 U.S. at 19.

This is not a *Pennhurst* case. Unlike the generalized preferences expressed in the statute under review in *Pennhurst*, "[t]here can be no mistaking that the stipulations of section 1396a(a) clearly constitute conditions that a state must meet to participate in the joint pro-

gram." *West Virginia Univ. Hosps.*, 885 F.2d at 20.[6] Eloquent testimony to this fact is found in the *amici curiae* brief of 46 states, in which the states freely acknowledge that their participation in the program carries with it an obligation to adhere to federal payment standards:

> [T]he court [of appeals] ignored the equally plain Congressional insistence on 'proper accountability' to ensure that payment rates are, in fact, reasonably adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with minimal state and federal quality of care requirements and insure access to health care by Medicaid beneficiaries. *See* S. Rep. 96-471, at 29.

Brief *Amici Curiae* of the States of Connecticut, *et al.*, at 15.

Moreover, the Court's understandable concern in *Pennhurst* that states receive adequate federal financial assistance comparable to the breadth of the obligation assumed obviously has no application in this context — as the Solicitor General points out, the federal government pays between 50 and 83 percent of the total cost of patient care. In fiscal 1988 alone, the federal contribution to the Medicaid program totaled $29 billion. *See* Brief of the United States at 2; *see also* Brief *Amici Curiae* of the

[6]This conclusion has been reached by every court of appeals to have considered the matter. *See Amisub (PSL), Inc. v. Colorado Dep't of Social Services*, 879 F.2d 789, 793, 794 (10th Cir. 1989); *Virginia Hosp. Ass'n*, 868 F.2d at 658; *Coos Bay Care Center v. Oregon*, 803 F.2d 1060, 1063 (9th Cir. 1986), *cert. granted*, 481 U.S. 1036, *vacated as moot*, 483 U.S. 1054 (1987). *See also St. Michael Hosp. of Franciscan Sisters, Milwaukee, Inc. v. Thompson*, No. 98-C-0620-C (W.D. Wis. Oct. 25, 1989) (available Dec. 15, 1989, on LEXIS, Genfed library, Dist file) (providers are beneficiaries of Medicaid Act by virtue of direct financial interest in rates established by states).

States of Connecticut, *et al.*, at vi n. 4 (federal share of program expenditures in 1986 was 58 percent). In this case Congress gave clear notice to the states that in voluntarily agreeing to participate in the Medicaid program, the states must adhere to minimum standards of payment, and has assisted the states in the attainment of this standard with a substantial financial commitment.

B. The Federal Courts Are Competent to Enforce the Reimbursement Standards of the Medicaid Act

Petitioners and *amici* urge that the Medicaid Act's payment standards are not sufficiently "specific and definite" to give rise to enforceable rights. *See* Brief of Petitioners at 12-17; Brief for the United States at 13, 17.

The "specific and definite" formulation originated in this Court's *Wright* opinion. But as this Court recently made clear in *Golden State Transit*, the criterion is not one of abstract specificity; rather, the test is pragmatic, and simply asks whether the obligation sought to be enforced is " 'sufficiently specific and definite' to be within 'the competence of the judiciary to enforce' . . . ." *Golden State Transit*, slip op. at 5 (quoting *Wright*, 479 U.S. at 432). In fact, the obligation sought to be enforced need not even be expressly stated. As this Court explained in *Golden State Transit:*

> A rule of law that is the product of judicial interpretation of a vague, ambiguous or incomplete statutory provision is no less binding than a rule that is based on the plain meaning of a statute. The violation of a federal right that has been found to be implicit in a statute's language and structure is as much a 'direct violation' of a right as is the violation of a right that is clearly set forth in the text of the statute.

Golden State Transit, slip op. at 8-9.

Petitioners' reliance on *Wright* is ironic, since in that case the Court rejected a similar charge that the statute was "too vague and amorphous" to establish enforceable rights. Petitioners argue that the "broad standard of 'reasonable and adequate'" established by subsection 13(A) "is not the kind of language Congress has used to create an enforceable right." Petitioners' Brief at 13. But it is precisely the "kind of language" that established the right recognized in *Wright*. There the Court rejected the argument that a requirement for a "reasonable allowance for utilities" is insufficiently definite, holding that such a provision is not "beyond the competence of the judiciary to enforce."[7] 479 U.S. at 432.

There is no need to speculate whether the payment standards of the Medicaid Act are sufficiently "specific and definite" for the judiciary to enforce. In practice the lower courts, when reviewing state agency plans and reimbursement methods, have proved themselves fully capable of determining whether the statutory standard has been satisfied. *See West Virginia Univ. Hosps.*, 885 F.2d at 30 (dual reimbursement system, under which out-of-state provider recovered only 54% of its treatment costs, fails to meet the reasonable and adequate requirement of subsection (13)(A)); *Amisub*, 879 F.2d at 799 ("overwhelming evidence" supports conclusion that application of across-the-board 46% reduction in Medicaid

[7]Petitioners and *amici* also stress language from the court of appeals' decision in *Edwards v. District of Columbia*, 821 F.2d 651 (D.C. Cir. 1987), reading *Pennhurst* "to distinguish statutory provisions that announce broad policy goals or general preferences from those that dictate specifically what the relevant government officials may and may not do." 831 F.2d at 656. Despite the further claim by these parties that this distinction precludes the recognition of enforceable rights in the Medicaid Act, *Edwards* itself cited section 1902(a)(13)(A) as an example of "narrow language of obligation" sufficient to secure rights under federal law. *See* 821 F.2d at 656 n. 5.

reimbursement does not reasonably or adequately compensate hospitals); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 518, 521 (5th Cir. 1983) (state plan complied with federal standards except for amendment disallowing certain legal fees and costs); *Ohio State Pharmaceutical Ass'n v. Creasy*, 587 F. Supp. 698, 707, 709 (S.D. Oh. 1984) (pharmacy dispensing fees were not so arbitrary and unreasonable as to violate the Act; however, delay in reimbursement of pharmacies violated section 1902(a)(37)); *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 362, 373 (N.D. Ill. 1983) (22 percent reduction in hospital reimbursement from prior year violated § 1902(a)(13)(A) and (a)(30)); *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116 (C.D. Cal. 1982) (California's proposed rates were not reasonable and adequate to meet the costs of efficiently and economically operated hospitals), *aff'd*, 705 F.2d 466 (9th Cir. 1983). In actual practice, therefore, the minimum reimbursement standards contained in the Medicaid Act have been well within the competence of the federal courts to enforce.[8]

[8]Judicial review of agency ratemaking did not begin with the Medicaid program. Federal courts have been frequently called upon to determine whether rates established by administrative agencies satisfy statutory directives no more "specific and definite" than the Medicaid Act's reimbursement standards. *See, e.g., Mobil Oil Corp. v. Federal Power Comm'n*, 417 U.S. 283, 301 (1974) (oil company challenged natural gas rates set by Federal Power Commission under Natural Gas Act requirement that rates be "just and reasonable"); *Atchison, Topeka & Santa Fe Ry. Co. v. Wichita Board of Trade*, 412 U.S. 800, 802, 813 (1973) (grain shippers alleged rate increases approved by Interstate Commerce Commission violated Interstate Commerce Act requirement that rates be "just and reasonable"); *Swift & Co. v. United States*, 343 U.S. 373, 375 (1952) (meat packer alleged rates approved by Interstate Commerce Commission violated Interstate Commerce Act requirement that carriers establish "just and reasonable charges"); *United States v. Chicago, Milwaukee,*

C. The Medicaid Act's Minimum Payment Standards Are Designed to Benefit Recipients and Providers

Petitioners and certain *amici* contend that health care providers which treat Medicaid patients have no rights under the Medicaid Act because the Act was not designed for their benefit. This argument does not take proper account of the critical role of health care providers within the Medicaid delivery system. The argument, moreover, proceeds from the flawed premise that a federal statute cannot benefit multiple parties.

Health care providers occupy a central role in the Medicaid system. It cannot be gainsaid that one of Congress's principal objectives, if not its principal purpose, was to provide medical care for the poor. Congress also recognized, however, that its purpose could not be achieved unless the states established payment rates sufficient to attract providers to the program, and to meet the costs reasonably incurred by providers in rendering medical assistance. This much is plain from the text of the statute, which requires that payment rates "meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services" under the program, and are sufficient "to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality." 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989). The concept is also embodied in the further directive that the states employ payment methods and procedures "as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care . . . ." § 1396(a)(30)(A) (West Supp. 1989). Similarly, subsection 37 requires the states to adopt claims review procedures that "ensure the proper and efficient payment of claims and management of the program . . . ." § 1396a(a)(37). Thus, the specific purposes of subsections (13)(A) and (30)(A) — the establishment of adequate reimbursement levels — may be taken as subsidiary but necessary steps in the attainment of the Congress's ultimate objective.

St. Paul & Pacific R.R. Co., 294 U.S. 499, 505 (1935) (coal shippers challenged schedule of rates set by Interstate Commerce Commission for the transportation of bituminous coal as not meeting "just and reasonable" requirement of Interstate Commerce Act).

The courts of appeals uniformly have concluded that these sections establish a minimum standard of reimbursement in favor of providers. As the Third Circuit cogently put the matter:

> We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights *only* to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement. The section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus the hospitals are the section's beneficiaries.'

West Virginia Univ. Hosps., 885 F.2d at 20 (original emphasis). Other courts have spoken of the "parallel interests" of providers and patients in minimally adequate Medicaid payment rates. *See Coos Bay Care Center*, 803 F.2d at 1063.[9]

[9]The courts have occasionally relied on the self-interest of one class of persons to serve the interests of another class. In *Singleton v. Wulff*, 428 U.S. 106 (1976), the Court held that two Missouri physi-

The legislative history of the 1981 Boren Amendment provides compelling support for this view. Congress plainly understood that minimum payment rates were necessary for the success of the Medicaid program. The Report of the House Budget Committee on H.R. 3982 reveals an unambiguous intent that providers receive fair and adequate reimbursement under the program. As the Committee stated:

> In permitting States greater flexibility in reimbursement system design, the Committee intends the States to ensure that such alternative systems provide fair and adequate compensation for services to Medicaid beneficiaries. The Committee intends that reimbursement levels for inpatient services must be adequate to assure that a sufficient number of facilities providing a sufficient amount of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to be able to obtain quality inpatient services for the treatment of their medical conditions. . . . *The Committee would be extremely concerned to see a substantial reduction in hospitals' willingness to treat Medicaid patients as a result of payment policy changes.*

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cians had standing to challenge the constitutionality of a Missouri Medicaid statute which excluded abortions that were not "medically indicated" from the purposes for which Medicaid benefits were available to needy persons. *See also Comtronics, Inc. v. Puerto Rico Tele. Co.*, 533 F.2d 701, 704-705 (1st Cir. 1977) (communications suppliers within the class of intended beneficiaries protected by § 203(b) of the Communications Act because, *inter alia*, suppliers vindicate consumer interest); *Planned Parenthood of Billings, Inc. v. Montana*, 648 F. Supp. 47, 50 (D. Mont. 1986) (family planning service has reinforceable rights under Public Health Service Act, a statute designed to improve availability of family planning services through the provision of grants).

> *The Committee believes that hospitals should be paid for the cost of their care to Medicaid patients in the most economical manner.* The Committee intends States to recognize that facilities that provide teaching services or other specialized tertiary care services that may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by the States recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services . . .
>
> Thus, while the Committee recognizes that in this time of economic constraint and reductions in Federal funds for Medicaid, States must be given the flexibility necessary to improve the Medicaid reimbursement mechanism, the Committee does not want such policies to result in arbitrary and unduly low reimbursement levels for hospital services.

H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 279, 293-294 (1981) (emphasis supplied).

The Committee expressed particular concern with the circumstances of providers which treat a disproportionate percentage of program recipients, such as the public hospitals that comprise *amicus* CAPH. The Committee directed that such providers receive fair and adequate compensation under the program:

> The Committee is also concerned about the impact of the States [sic] payment practices on facilities that treat a large volume of Medicaid patients and patients who are not covered by other third party payors. The Committee intends

> that payment for inpatient services take into account the special costs of hospitals whose patient populations are disproportionately composed of such individuals.
>
> Therefore, the Committee bill requires that States, in determining the appropriate reimbursement rate for inpatient hospital services, and in developing a prospective payment methodology, take into account the special costs of hospitals whose patient populations are disproportionally composed of individuals who are either provided medical assistance under the State plan or who have no source of third party payment for such services.

Id. at 294-295.

There is no question that the Committee was concerned with the financial well being of such providers, independent of their role within the Medicaid delivery system. In directing the Secretary of Health and Human Services to develop reimbursement methods "based on the complexity and severity of cases treated at each hospital," and to "analyze the impact of the reimbursement methodology . . . on the financial viability of institutions whose patient populations are disproportionately composed of Medicaid patients or patients without third party coverage." *Id.* at 297 (emphasis supplied).

The Boren Amendment, as passed, incorporated much of H.R. 3982. Indeed, the Secretary relied extensively on the Budget Committee Report in formulating the Act's interim regulations. *See* 46 Fed. Reg. 47964, 47969 (1981). The Conference Committee on the Boren Amendment shared these concerns. In its report, the Committee expressed its intent that state payment rates adequately compensate hospitals for the care of Medicaid patients:

> [T]he conferees intend that State hospital reimbursement policy should meet the costs that must be incurred by efficiently-administered hospitals in providing covered care and services to Medicaid eligibles as well as the costs required to provide care in conformity with State and Federal requirements.

H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 962 (*reprinted in* 1981 U.S. Cong. & Ad. News 1010, 1324). The Conference Committee was also concerned that so-called "disproportionate share" hospitals receive adequate reimbursement from the States:

> The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a state take into account the special situation that exists in these institutions in developing their rates.

Id.

In sum, notwithstanding Congress's purpose to give the states added flexibility in establishing payment rates, Congress was equally concerned that payment rates meet the costs that must be incurred by efficiently and economically operated hospitals, and take into account the circumstances of disproportionate share providers. These concerns "impl[y] an intent to supply hospitals with an indispensable right to enforce state compliance with federal standards that, whether strictly or loosely, govern state reimbursement methodologies." *West Virginia Univ. Hosps.*, 885 F.2d at 21.

HCFA also recognizes that providers have certain rights under the Medicaid system. Applying subsection 37 of the Act, in 1984 HCFA adopted regulations requiring each administering agency to "provide an appeals or

exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(c) (1988). *See* 48 Fed. Reg. 56046, 56052 (1983). The agency observed that the purpose of the appeals process was to permit providers to challenge payment rates established by the state:

> The intent behind the Federal appeals provision is to provide a means for facilities to seek reimbursement relief upon a proper finding by the State agency ... We believe that fair and reasonable rate adjustments are implicit in an appeals process.

48 Fed. Reg. at 56052 (1983).[10]

It is plain from subsection 37(B), HCFA's implementing regulations and HCFA's explanatory remarks that HCFA understands providers to have certain rights of review under the Act. An appeals mechanism for providers only makes sense if providers have certain "rights" on which to base an appeal. As HCFA's own regulations state, "fair and reasonable rate adjustments are implicit in an appeals process ...."

[10]If providers are not entitled to bring federal court actions to enforce rights recognized under section 1902(a), it would presumably be left to the indigent program recipients to bring such actions. In fact, as shown on Appendix A to the brief of *Amici Curiae* States, program beneficiaries and organizations that represent them rarely bring such cases. Absent the right of a healthcare provider to obtain judicial review of the adequacy of Medicaid payment rates, such a challenge would only be brought on the basis of hospital-by-hospital year-by-year administrative appeals. Hospitals often elect not to pursue such appeals because of the costs and burdens of the process.

II.

CONGRESS HAS NOT SPECIFICALLY FORECLOSED SECTION 1983 ENFORCEMENT OF THE MEDICAID ACT'S REIMBURSEMENT STANDARDS

Petitioners and certain *amici* also contend that "congressional intent to foreclose a federal cause of action can be implied" from the existence of "federally mandated appeals procedures." *See* Brief of Petitioners at 22-26. The limited review procedures available under the program, however, do not approach the "comprehensive enforcement mechanis[m] for protection of a federal right," *Smith*, 468 U.S. at 1003, from which an intent to foreclose use of section 1983 can be inferred.

A compelling showing is required to establish that Congress intended to foreclose a private remedy under section 1983. The Court does " 'not lightly conclude that Congress intended to preclude reliance on § 1983 as a remedy' for the deprivation of a federally secured right." *Wright*, 479 U.S. at 423-424 (quoting *Smith*, 468 U.S. at 1012). "[I]f there is a state deprivation of a 'right' secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright*, 479 U.S. at 423. In the absence of an express provision, congressional intent to foreclose has usually been found in the establishment of a comprehensive remedial scheme. *See, e.g., Sea Clammers*, 453 U.S. at 20; *Smith*, 468 U.S. at 1012.

The Medicaid Act contains no provision that expressly forecloses the use of the section 1983 remedy. Although Congress has established some review procedures, these procedures are not "sufficiently comprehensive ... to demonstrate Congressional intent to preclude the remedy of suits under § 1983.' " *Wright*, 479 U.S. at 424 (quoting *Sea Clammers*, 453 U.S. at 20).

There are two potential means by which a state's failure to establish reasonable payment rates may be enforced. First, as previously discussed, the implementing regulations require the state administering agency to provide an appeals procedure "that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(c) (1988). However, "the existence of a state administrative remedy does not ordinarily foreclose resort to § 1983." *Wright,* 479 U.S. at 427-28 (citing *Patsy v. Board of Regents,* 457 U.S. 496, 516 (1982)). This principle applies with particular force here, where the regulations vest the state administrative agency with substantial discretion to confine the "issues" on which an appeal will be permitted. The Court of Appeals found, in fact, that Virginia's appeals system does not permit consideration of some of the arguments made in VHA's complaint. *See* 868 F.2d at 661 n. 9.[11]

The Act also permits the Secretary of Health and Human Services to discontinue federal funding if a state plan does not meet the program requirements. *See* 42 U.S.C.A. § 1396c (West Supp. 1989). Under *Wright,* however, "considerable authority to oversee the operation" of the program, and even the power to cut off federal funds,

[11]A limited scope of review is not unique to Virginia's appeal system. Pennsylvania's appeals procedure permits providers to challenge the *application* of the state's reimbursement methodology, but not the validity of the methodology itself. *See West Virginia Univ. Hosps., Inc. v. Casey,* 701 F. Supp. 496, 510 (M.D. Pa. 1988), *aff'd in part, rev'd in part,* 885 F.2d 11 (3d Cir. 1989). The same is true in California. *See* 22 Cal. Code Regs. § 51536(h)(1) & (i)(2) (provider may not pursue administrative adjustment or appeal of methods used for determining rate factors, or use of certain limitations on payment rates); § 51539(d)(2) (agency's use of payment limiting regulation not subject to administrative review or adjustment).

are mere "generalized powers [that] are insufficient to indicate a congressional intention to foreclose § 1983 remedies." *Wright,* 479 U.S. at 424, 428. *See West Virginia Univ. Hosps.,* 885 F.2d at 22 ("Title XIX gives no indication that the cut-off of funds to the federal agency is intended to supplant a section 1983 remedy.").

Petitioners contend that Congress's intent to foreclose a section 1983 action may be divined from HCFA's "comprehensive program of ongoing state plan reviews [and] audits . . . " Brief for Petitioners at 24. Indeed, petitioners assert that "HCFA vigorously enforces the Medicaid Act," *id.* at 23, and that its "oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright* to be insufficient to indicate legislative foreclosure of § 1983 remedies." *Id.* at 24 n. 17.

In fact, HCFA's oversight is neither "comprehensive" nor "intensive," either in design or in operation. HCFA's review of payment methods contained in a state's Medicaid plan is "cursory at best. In essence, its review is limited to whether the 'documentation submitted by the State Medicaid Agency complies with procedural requirements.' " *Amisub,* 879 F.2d at 794. The agency does not " 'look behind' the State's [assurances] concerning the adequacy of its reimbursement rate." *West Virginia Univ. Hosps.,* 701 F. Supp. 496, 510 (M.D. Pa. 1988) (finding of fact no. 201), *aff'd in part, rev'd in part,* 885 F.2d 11 (3d Cir. 1989); *see also Amisub (PSL), Inc. v. State of Colorado Dep't of Social Services,* 698 F. Supp. 217, 219 (D. Colo. 1988) (HCFA's review of Colorado's payment rates is "cursory" and is limited to determination whether documentation supplied by the agency complies with procedural requirements), *rev'd on other grounds,* 879 F.2d 789 (10th Cir. 1989).

Indeed, a compelling refutation of petitioner's assertions is contained in the Brief of the Solicitor General, a

brief ironically submitted in support of Virginia's position. The unambiguous theme that emerges from the Solicitor General's brief is that Congress intended HCFA to exercise *minimal* review of State payment methodologies. For example, the Solicitor General claims that "[i]n enacting the Boren Amendment . . . Congress made clear that it did not envision rigorous Federal scrutiny of the State's 'assurances' under Section 1396a(a)(13)(A)," Brief of United States at 20, and that "[c]onsistently with this legislative history, the Secretary has maintained that Section 1396a(a)(13)(A) does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted." *Id.* at 21. This does not describe an enforcement mechanism "sufficiently comprehensive and effective to raise a clear inference that Congress intended to foreclose a section 1983 cause of action." *Wright,* 479 U.S. at 425.

Petitioners and *amici* also argue that recognition of a section 1983 remedy would be duplicative, wasteful of resources or result in thousands of routine cases being brought.[12] This claim is not borne out by the facts. Since the inception of the Medicaid program in 1966, *amici* have found only 84 reported cases in all federal and state courts involving claims by providers to enforce payment rights under section 1902(a) of the Act.

A hospital-by-hospital pursuit of administrative remedies followed by judicial review as suggested by petitioners (at 9-10) and *amici* would almost certainly add substantially to the number of Medicaid challenges and the burden of states in responding to them.[13] That only 31

[12]Brief of Petitioners at 24-25; Brief of United States at 2-3, 23; Brief of *Amici Curiae* States at v-vi & n. 2

[13]The litigation strategy advocated by petitioners and particularly by *Amicus* United States would potentially lead to an abuse of the

currently pending cases exist on various Medicaid issues, involving 18 separate state Medicaid plans, testifies to the relative paucity of such litigation. *See* Appendix A to Brief of *Amici Curiae* States. In this case, a single action by the Virginia Hospital Association seeks to vindicate rights on behalf of almost all of the hospitals in the state. Joint Appendix at 5. Short of eliminating litigation altogether, it is difficult to conceive of a more efficient use of state resources required to respond to Medicaid challenges.

judicial system. As an example, the Secretary under the analogous Medicare program required literally thousands of administrative appeals, scores of federal court actions, and eleven federal courts of appeals to address a single payment issue involving a hospital's right to reimbursement of malpractice insurance costs. *See Mason General Hosp. v. Secretary of Dep't of Health and Human Services,* 809 F.2d 1220, 1223 n. 2 (6th Cir. 1987) and cases cited therein; *see also Tallahassee Memorial Regional Medical Center v. Bowen,* 815 F.2d 1435 (11th Cir. 1987), *cert. denied,* ___ U.S. ___ (1988); *Bethesda Community Hosp. v. Bowen,* 810 F.2d 558 (2d Cir. 1986), *rev'd,* ___ U.S. ___ (1988); *Walter O. Boswell Memorial Hosp. v. Heckler,* 749 F.2d 788 (D.C. Cir. 1985). As a result of the Secretary's requirement that each hospital separately pursue its administrative claims regarding payment of malpractice insurance costs, over 80 such cases were filed in U.S. District court for the District of Columbia since 1982. *See, e.g., Walter O. Boswell Memorial Hosp. v. Heckler,* Civil Action No. 82-0710 and cases consolidated with it; *Ardmore Adventist Hosp. v. Sullivan,* Civil Action No. 85-2841 and cases consolidated with it.

CONCLUSION

The judgment of the United States Court of Appeals for the Fourth Circuit should be affirmed.

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December 20, 1989

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA
COUNTY OF LOS ANGELES } ss.:

I am a citizen of the United States and a resident of or employed in the City of Los Angeles, County of Los Angeles; I am over the age of 18 years and not a party to the within action; my business address is 1706 Maple Avenue, Los Angeles, California 90015.

On December 20, 1989, I served the within Brief of *Amici Curiae* in re: "Gerald L. Baliles v. The Virginia Hospital Association" in the United States Supreme Court, October Term 1989, No. 88-2043, on all parties interested in said action, by placing three true copies thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mail box at Los Angeles, California, addressed as follows:

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All parties required to be served have been served.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on December 20, 1989, at Los Angeles, California.

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